Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
SUITE 204
5445 LA SIERRA DRIVE
DALLAS TX 75231

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-09-7526-01

MFDR Date Received
April 10, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient performed Psychological Testing. The claim was paid incorrectly. CPT code 96102 was not paid and CPT code 96101 was paid incorrectly. Please refer to the attached preauthorization letter."

Amount in Dispute: $156.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed under CPT Codes 96102, 96101, and 90889. Carrier has excluded reimbursement under CPT Code 96102 for testing by a technician. CMS's reimbursement policyprohibits [sic] reimbursement under CPT 96102 when billed for the same date of service as CPT 96101. Carrier issued appropriate reimbursement under CPT 96101 and correctly excluded reimbursement under CPT 96102."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2009	96102	$126.44	$0.00
February 9, 2009	96101	$30.52	$30.52
TOTAL		$156.96	$30.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - W1 –Workers Compensation Sate Fee Schedule Adjustment
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on August 3, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor billed CPT codes 96012, 96101 and 90889 rendered on February 6, 2009. The division completed NCCI edits in order to determine correct reimbursement. The following was identified:

   Per CCI Guidelines, Procedure Code 96102 [PSYCHOLOGICAL TESTING ADMN BY TECH PR HR] has a CCI conflict with Procedure Code 96101 [PSYCHOLOGICAL TESTING PR HR WITH PATIENT]. Review documentation to determine if a modifier is appropriate. Review of the CMS-1500 does not identify that a modifier was appended to CPT code 96012, as a result, reimbursement cannot be recommended for CPT code 96102.

   No NCCI edit conflicts were identified for CPT code 96101, as a result the division will review the disputed charge pursuant to 28 Texas Administrative Code § 134.203 (c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title." .

   The Medical Fee Dispute Resolution's calculation resulted in a MAR amount of $126.82. The insurance carrier issued payment in the amount of $81.00 for CPT code 96101. The requestor seeks an additional reimbursement in the amount of $30.52, for a total MAR amount identified by the requestor of $111.52, therefore the requestor is entitled to an additional reimbursement in the amount $30.52 for CPT code 96101 rendered on February 6, 2009.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $30.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $30.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.